

# Waiver Billing: Elderly and Physically Disabled Waivers

Submitting Paper Claims

09/11/2013

# Introduction

- This Web-ex addresses Paper Claims for HCBS Elderly and Physically Disabled Waiver consumers ONLY
- Providers who enrolled after 7/1/13 were required to register for electronic fund payments (EFT) payments and electronic Remittance Advices (RA)
- Providers currently receiving paper checks and/or paper RAs must transition to EFT and electronic RAs
- New “Health Enterprise” payment software is targeting electronic claim submission

# Montana's HCBS Waivers

- Home and Community-Based Services (HCBS)
- Montana has four waivers:
  - Developmentally Disabled
  - Elderly and Physically Disabled
  - Severe Disabling Mental Illness (SDMI)
  - Psychiatric Residential Treatment Facilities (PRTF)

This web-ex specifically addresses billing for the Elderly and Physically Disabled waivers.

# Who's on First?

Community Services Bureau (CSB)

Senior and Long Term Care Division (SLTC)

Department of Public Health and Human Services (DPHHS)

CSB oversees and administers the Elderly and Physically Disabled waivers.

Case Management Teams (CMT) manage “slots” for each Consumer

Xerox contracts with DPHHS to process and pay Medicaid claims.

# Case Management Teams

- Consumer must meet eligibility requirements
- Consumer works with CMT
- Limited amount of available funding
  - “Slots”
- CMT refers authorized services to Waiver Provider
  - Prior Authorization

# Prior Authorization

- Consumer demographics and Medicaid ID #
- Provider name and Provider ID # (if known)
- Primary diagnosis/ ICD-9 CM diagnosis code
- Authorized Procedure Codes and Modifiers
- Dollar amount or number of units per service
- Date Span per service
- CMT contact name and phone #
- **PRIOR AUTHORIZATION NUMBER!**

# Waiver Providers

- Must be specifically enrolled as HCBS provider
- Some Provider Types such as Durable Medical Equipment (DME) must enroll twice
- Provider Type 28
- “Atypical” versus “Typical”
  - National Provider Identification (NPI)  
**is NOT required !!**

# Waiver Providers (cont.)

- All Waiver Providers have a “CHARGE FILE”
- CMT Approved List of Provider's billable:
  - Procedure Codes
  - Rates
  - Effective Dates of Service
- CSB manages data in MMIS software



# Provider Responsibilities

- Know the regulations and requirements:

- HCBS Manual, Section 600

- <http://www.dphhs.mt.gov/sltc/services/communityservices/index.shtml>

- Administrative Rules of Montana (ARM)  
37.85.406 Billing, Reimbursement, Claims  
Processing and Payment

- <http://www.mtrules.org/gateway/Department.asp?DeptNo=37>

- Montana Medicaid Provider Information

- <http://medicaidprovider.hhs.mt.gov/>

# Provider Responsibilities (cont.)

- Monitor changes, upcoming events, and training opportunities

- **Claim Jumper Newsletter**

- <http://medicaidprovider.hhs.mt.gov/providerpages/disclaimercj.shtml>

- New issue on the first of the month
    - DPHHS and Xerox both post all important information in the Claim Jumper!!!

# Provider Responsibilities (cont.)

- “Montana Medicaid Provider Information” site
    - “Resources by Provider Type”
      - “General Information for Providers” Manual
      - Fee schedules
      - ARM link
    - Announcements
    - Forms
    - Training schedule
    - Claim Jumper link
- <http://medicaidprovider.hhs.mt.gov/>

# Provider Responsibilities (cont.)

- Report any changes in provider contact information, addresses, phone number, immediately to Xerox
  - Montana Medicaid Provider Home Page  
<http://medicaidprovider.hhs.mt.gov/index.shtml>
    - Forms/ Address Correction Form

# Provider Responsibilities (cont.)

Verify consumer eligibility each month !!

## ○ **Montana Access To Health**

(aka MATH or the Web Portal)

- Enroll online at:

<https://mtaccesstohealth.acs-shc.com/mt/general/home.do>

# Waiver Billing Requirements

- Medicaid Waiver Consumer
- Waiver Provider
- Prior Authorization for requested service(s)
- Provider authorized to deliver the requested services
  - Charge File

# Waiver Eligibility

- Medicaid eligibility is **not** Waiver eligibility
- Office of Public Assistance (OPA) re-evaluates Consumer eligibility every month
- HIPAA and privacy
- If talking to OPA, the question to ask is:
  - **“Has WAIVER been ISSUED?”**

# Waiver Eligibility (cont.)

- Check MATH for Waiver eligibility

Eligibility Spans		About HMK/HMKPlus			
Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Full Coverage	05/01/2010	01/31/2013
Message Text: Elderly/Physically Disabled Waiver					

- May not be available at first of the month
- Tip: try using later eligibility date
  - Ex. 05/15/13 rather than 05/01/13



# Waiver Eligibility (cont.)

- OPA challenges
- Most common reason claims deny
- **SAVE TIME! Confirm eligibility before Billing!**

# Procedure Codes and Modifiers

- All Waiver Procedure Codes must be billed with a UA modifier
  - Exceptions: T2022 and T1016 Case Management
- If multiple modifiers are to be used, UA must be first
- Additional modifiers:
  - **TE**: indicates nurse supervision
    - As opposed to attendant services
    - Use together with UA : ex T1001 UA TE

# Procedure Codes and Modifiers (cont.)

- **TS:** use when late timesheets are received for dates of service that have already been paid
  - Use Modifier instead of Adjusting claim
  - Use for these procedure codes ONLY:  
S0215, S5125, S5130, S9123, S9124, T1002, T1003, T1005, and T1019

# Clean Claims and Timely Filing

- ARM 37.85.406: “**Clean claim** means a claim that can be processed without additional information or documentation from or action by the provider of the service.”
- ARM 37.85.406: “Date of submission to the Medicaid program is the date the claim is stamped “received” by the department or its designee” (i.e. Xerox)
- **Timely Filing:** Maximum of 12 months from the date of the service to submit a clean claim
  - All errors must be worked for the claim to be clean
  - 05/31/13 service date, clean claim by 05/30/14

# CMS 1500 – Paper Claim

- Downloadable form NOT available
- Must be “regulation” size
- Process is very streamlined for our waiver
- Only the fields *specifically identified* are required for Elderly and Physically Disabled Waiver
- Additional fields may cause claim to deny

# CMS 1500

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0096

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> PRIVATE (Private #) <input type="checkbox"/> CHAMPVA (Champion #) <input type="checkbox"/> OTHER (Other #) <input type="checkbox"/>										2. INSURED'S I.D. NUMBER (For Program in Item 1)									
3. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. INSURED'S ADDRESS (No., Street)									
CITY										CITY									
STATE										STATE									
ZIP CODE										ZIP CODE									
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										8. INSURED'S POLICY GROUP OR PROGRAM NUMBER									
9. OTHER INSURED'S POLICY OR GROUP NUMBER										10. INSURED'S DATE OF BIRTH									
11. OTHER INSURED'S DATE OF BIRTH										12. EMPLOYER'S NAME OR SCHOOL NAME									
13. EMPLOYER'S NAME OR SCHOOL NAME										14. INSURANCE PLAN NAME OR PROGRAM NAME									
15. INSURANCE PLAN NAME OR PROGRAM NAME										16. IS THERE ANOTHER REAL TO BENEFIT PLAN?									
17. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. (Patient's or Authorized Person's Signature) I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)									
19. SIGNED										20. SIGNED									
21. DATE OF CURRENT- (MM/DD/YY)										22. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM/DD/YY TO MM/DD/YY)									
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE										24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)									
25. RESERVED FOR LOCAL USE										26. OUTSIDE UNIT? \$ CHARGES									
27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 28 by Line)										28. MEDICAID RESUBMISSION CODE									
29. MEDICAID RESUBMISSION CODE										30. PRIOR AUTHORIZATION NUMBER									
31. A. DATE(S) OF SERVICE (From MM/DD/YY To MM/DD/YY)										32. B. PROCEDURE(S), SERVICE(S) OR SUPPLY(S) (CPT/HCPCS MODIFIER)									
33. C. DIAGNOSIS (ICD-9-CM)										34. D. CHARGES \$ CHARGES									
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411. Q. CHARGES \$ CHARGES										412. R. CHARGES \$ CHARGES									
413. S. CHARGES \$ CHARGES										414. T. CHARGES \$ CHARGES									
415. U. CHARGES \$ CHARGES										416. V. CHARGES \$ CHARGES									
417. W. CHARGES \$ CHARGES										418. X. CHARGES \$ CHARGES									
419. Y. CHARGES \$ CHARGES										420. Z. CHARGES \$ CHARGES									
421. A. CHARGES \$ CHARGES										422. B. CHARGES \$ CHARGES									
423. C. CHARGES \$ CHARGES										424. D. CHARGES \$ CHARGES									
425. E. CHARGES \$ CHARGES										426. F. CHARGES \$ CHARGES									
427. G. CHARGES \$ CHARGES										428. H. CHARGES \$ CHARGES									
429. I. CHARGES \$ CHARGES										430. J. CHARGES \$ CHARGES									
431. K. CHARGES \$ CHARGES										432. L. CHARGES \$ CHARGES									
433. M. CHARGES \$ CHARGES										434. N. CHARGES \$ CHARGES									
435. O. CHARGES \$ CHARGES										436. P. CHARGES \$ CHARGES									
437. Q. CHARGES \$ CHARGES										438. R. CHARGES \$ CHARGES									
439. S. CHARGES \$ CHARGES										440. T. CHARGES \$ CHARGES									
441. U. CHARGES \$ CHARGES										442. V. CHARGES \$ CHARGES									
443. W. CHARGES \$ CHARGES										444. X. CHARGES \$ CHARGES									
445. Y. CHARGES \$ CHARGES										446. Z. CHARGES \$ CHARGES									
447. A. CHARGES \$ CHARGES										448. B. CHARGES \$ CHARGES									
449. C. CHARGES \$ CHARGES										450. D. CHARGES \$ CHARGES									
451. E. CHARGES \$ CHARGES										45									

# Required Fields

- 1a – Insured's ID Number

PICA	
3	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
<div></div>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
<div></div>	

- Medicaid ID as shown on Medicaid ID Card

# Required Fields (cont.)

- 2- Patient's Name (Last Name, First Name, Middle Initial)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	:
	:
5. PATIENT'S ADDRESS (No., Street)	:

- As shown on Medicaid ID Card



# Required Fields (cont.)

- 10d. – “Reserved for Local Use

The diagram shows a rectangular form field with a light blue background. A yellow rectangular label with the text "10d. RESERVED FOR LOCAL USE" is positioned in the upper left corner of the field. Below this label, there is a yellow rectangular area, possibly representing a signature or a specific data entry field. The entire field is enclosed in a thin black border.

G & SIGNING THIS FORM.

- - Approved ALTERNATIVE field for Medicaid ID
  - Use instead of 1a

# Required Fields (cont.)

- 21 – Diagnosis or Nature of Illness or Injury  
(Relate Items 1, 2, 3, or 4 to Item 24E by Line)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1.	<input type="text"/>	.	<input type="text"/>
3.	<input type="text"/>	.	<input type="text"/>
2.	<input type="text"/>	.	<input type="text"/>
4.	<input type="text"/>	.	<input type="text"/>
24. A.	DATE(S) OF SERVICE	B.	C.
	From To	PLACE OF	D. PROCEDURES, SERVICES, OR SU
			(Explain Unusual Circumstances)

- Decimal point on form lines up with code

# Required Fields (cont.)

- 23 – Prior Authorization Number

23. PRIOR AUTHORIZATION NUMBER

- - Must be included on claim
- - Must be the correct PA for the billed services

# Required Fields (cont.)

- 24. A. – Dates of Service

24. A. DATE(S) OF SERVICE						
From			To			
MM	DD	YY	MM	DD	YY	

- Two digit format: MM | DD | YY

# Required Fields (cont.)

- 24. B. – Place of Service

24. A. DATE(S) OF SERVICE						B.
From			To			PLACE OF SERVICE
MM	DD	YY	MM	DD	YY	

- Complete listing (beginning on page 20):

<http://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html>

- S0215 UA – Transportation-Miles can't use "12 – Home"

# Required Fields (cont.)

- 24. D. – Procedures, Services, or Supplies

2.     .						4.     .						
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				D
From				To				CPT/HCPCS		MODIFIER		
MM	DD	YY	MM	DD	YY							

- “CPT” is the Procedure Code
- “UA” modifier ALWAYS REQUIRED
- “UA” before “TE” or “TS”

# Required Fields (cont.)

- 24. E. – Diagnosis Pointer

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											
1.				3.							
2.				4.							
24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	
From To						PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER	POINTER	

- Works in conjunction with 21
- “1” primary diagnosis
- Multiple: 1,2,3,4

# Required Fields (cont.)

- 24. F. – Total Charges

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.
From To						PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER	POINTER	

- Dollars to the left of the dashed line
- Cents to the right of the dashed line



- 24. G. – Days or Units

24.	A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E.	F.	G.	EP F
	From			To			PLACE OF SERVICE	EMG		DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
1													

# Required Fields (cont.)

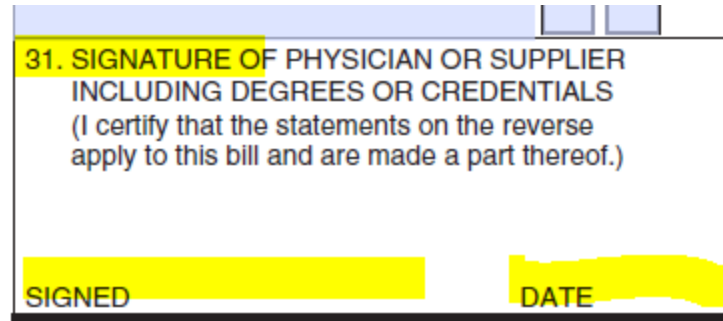
- 28. – Total Charge

F. \$ CHARGES		G. DAYS OR UNIT	
28. TOTAL CHARGE			
\$			

- Sum of column “ 24. F.

# Required Fields (cont.)

- 31. – Signature and Date



The screenshot shows a form section with a yellow header bar containing the text "31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)". Below this header, there are two yellow rectangular boxes. The left box is labeled "SIGNED" and the right box is labeled "DATE".

NUCC Instruction Manual available at: [www.1](http://www.1)

- Signature Date must be *after* the last date of service on the claim!

# Required Fields (cont.)

- 33. Billing Provider Info & PH #

The image shows a portion of the CMS-1500 form, specifically section 33. The title "33. BILLING PROVIDER INFO & PH #" is highlighted in yellow. Below the title, there are three lines of text, all of which are redacted with yellow boxes. At the bottom of the section, there are two sub-sections labeled "a." and "b.". Sub-section "a." is labeled "NPI" and contains a redacted field. Sub-section "b." is labeled "PH" and contains a redacted field. Below the form, the text "APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)" is visible.

33. BILLING PROVIDER INFO & PH #	
[Redacted]	
[Redacted]	
[Redacted]	
a. NPI	b. PH

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

- Billing Contact Phone #
- Zip + 4 for Zip Code

# Required Fields (cont.)

- 33. a. – NPI: National Provider Identification

33. BILLING PROVIDER INFO & PH #

a. b.

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

- **LEAVE BLANK!**
- A very few providers may already be successfully billing with an NPI. If this is your facility, please continue your current practice.

# Required Fields (cont.)

- 33. b. – “G20” plus Atypical Provider Number

33. BILLING PROVIDER INFO & PH #

a. NPI

b. [Redacted]

APPROVED OMB 0000-0000 FORM OMB 4500 (03-05)

- Atypical Provider
  - Use 6 digits
  - Ex: G20123456

# Remittance Advice

- Access electronically through MATH
- Reconcile claims and payments weekly
- Three sections: Paid, Denied, Pending
  - Paid claims can be Adjusted
  - Denied claims can be corrected and resubmitted
  - Pending claims must complete cycle
- Work the Reason and Remark codes
- 12 months from Service Date = “Clean Claim”

# Common Reasons for Denials

- Claim submitted before eligibility in place
- Claim spans eligible and ineligible spans
- PA on claim is not correct for time span
- Invalid Diagnosis Code
- Missing Diagnosis Code Pointer
- Missing UA modifier
- Duplicate claim
- Overbilling the PA



# Common Reason and Remark Codes

- 4 - Procedure code is inconsistent with the modifier or the modifier is missing
- 15 - The authorization number is missing, invalid, or does not apply to the billed services or provider
- 18 - Exact duplicate
- 29 – Time Limit for Filing has expired
- 31 – Patient cannot be identified as our insured
- 119 – Benefit Maximum for this time period has been reached
- 133 – Disposition of claim is pending further review

# Individual Adjustment Request

- Form on “Montana Medicaid Provider Information” homepage/ Forms
- Box A – Complete in full
- Box B – Only the data being changed
  - In 8, “Please update PA # 12345678”
- Attach Remittance Advice
- Allow 4 weeks for processing

# Individual

# Adjustment Request



## Montana Health Care Programs Medicaid • Mental Health Services Plan • Healthy Montana Kids Individual Adjustment Request

### Instructions:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete only the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the Remittance Advices and Adjustments chapter in your program manual or the General Information for Providers manual, or call Provider Relations at 1.800.524.3558 (Montana and out-of-state providers) or 406.442.1837 (Helena).

### A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address	3. Internal Control Number (ICN)
Name _____	_____
Street or P.O. Box _____	4. NPI/API _____
City _____ State _____ ZIP _____	5. Client ID Number _____
2. Client Name _____	6. Date of Payment _____
_____	7. Amount of Payment \$ _____

### B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDG/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other Remarks (Be specific.)			

Signature \_\_\_\_\_ Date \_\_\_\_\_

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims  
P.O. Box 8000  
Helena, MT 59604

Updated 03/2013

# Individual Adjustment Request (cont.)

- A.3. Internal Control Number (ICN) from RA

PAID CLAIMS - MISCELLANEOUS CLAIM							
4082668		05162013 05222013	2.000	T2031 UA	122.46	122.46	
ICN 01322511815102000 PATIENT NUMBER-							
***CLAIM TOTAL*****					122.46	122.46	

- Individual transaction identification number
- 17 digits long

---

3. Internal Control Number (ICN)

---

# Individual Adjustment Request (cont.)

- A. 4. NPI/API: **Atypical** Provider Number
- A. 5. Client ID Number: pull from original claim
  - RAs only show Medicaid ID
  - If SSN was originally submitted, use SSN

# Individual Adjustment Request (cont.)

- Box B: Changes only

B. Complete only the items which need to be corrected.			
Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			

# Individual Adjustment Request (cont.)

- Ex. Changing only number of units

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	LINE 1	4	1

- Ex. Changing units and Billed Amount

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	Line 1	4	1
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount	Line 1	40.00	10.00

# Individual Adjustment Request (cont.)

- Box B. 8. Other/Remarks (Be specific)
  - Be descriptive but succinct
  - Technician does not see the original claim
  - Always include: "PLEASE UPDATE PA # xxxxxxxx"
- Corrected claim is not required
  - However, if there are many changes to claim a corrected claim may help with processing
- Attach Remittance Advice



# Claim Credit

- “Claim Credit” to reverse a Paid Claim
- Use Individual Adjustment Request form
- **CLAIM CREDIT** in upper right hand corner
- Complete Box A
- Box B only needs “8. Other/ Remarks”
  - “Please **CLAIM CREDIT**”
  - “Please update PA # xxxxxxxx”
- After reversed, new claim(s) can be submitted

# Upcoming Events

- Transition to EFTs and electronic RAs
- ICD 10 – Overhaul of diagnosis codes
  - 10/01/2014
- Health Enterprise
  - Spring 2015

**Watch the CLAIM JUMPER !**

# Contacts

Elderly and Physically Disabled Waiver:

Sandy Karrick-Nelson, Claims Examiner

406-444-4142

Fax: 406-444-7743 “Attn: Sandy”

[skarrick-nelson@mt.gov](mailto:skarrick-nelson@mt.gov)

Craig Bender, Program Specialist

Provider Enrollment/ Charge File

406-444-4376

[CBender2@mt.gov](mailto:CBender2@mt.gov)

# Contacts

## Severe Disabling Mental Illness (SDMI)

Helen Higgins

[hhiggins@mt.gov](mailto:hhiggins@mt.gov)

406-444-3055

## Developmental Disabilities

Karen Cech

[KCech@mt.gov](mailto:KCech@mt.gov)

406-444-2995